

NOV 18 1937

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County JacksonTownship KawCity Kansas CityRegistration District No. 399Primary Registration District No. 1002(No. General Hospital)File No. 36690Registered No. 2229

St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Unknown

(Usual place of abode)

Ward _____

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 19 1905

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Barber

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Missouri13. NAME John Schultz

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Missouri15. MAIDEN NAME Verna Workman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Missouri17. INFORMANT Mrs Verna Boston(ADDRESS) St. Charles Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Floral HillDATE 10/13/3719. UNDERTAKER Quirk & Tobin Co.(ADDRESS) 20 West Linwood20. FILED Oct 13, 37M. M. Brown

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/15/37, 19

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19

I last saw him alive on _____, 19. Death is said

to have occurred on the date stated above, at _____

The principal cause of death and related causes of importance were as follows:

Date of onset

Lobar Pneumonia
Pneumococci meningitisOther contributory causes of importance: 108

Name of operation _____ Date of _____

What test confirmed diagnosis _____ Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19

Where did injury occur? _____

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury directly related to occupation of deceased?

If so, specify _____

(Signed) W. H. H. H.(Attest) W. H. H. H.

M. D.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

CAUSE OF DEATH in 1914-15. For the purpose of the present report, the cause of death is classified as follows:—

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

36690

Do not use this space.

Registered No. 4119

1. PLACE OF DEATH

(a) County Jackson

Registration District No. 399

(b) Township

Primary Registration District No. 1002

(c) City Kansas City

(d) Street No.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred

yrs. mos. ds.

(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Artie Schultz

(a) Residence, No.

St.

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)

M

W

single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

32

3

16

OCCUPATION

8. Trade, profession, or particular kind of
work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work
was done, as saw mill, bank, etc.

10. Date deceased last worked at
this occupation (month and
year)

11. Total time (years)
spent in this
occupation

12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

17. INFORMANT
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19.

19. FUNERAL DIRECTOR
(ADDRESS)

20. FILED

10/13, 1937 M. D. Brown

Local Registrar

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Name of operation

Date of

What test confirmed diagnosis?

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23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury....., 19.....

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.

S-36690